EXHIBIT

1

PROOF OF CLAIM

REHABILITATION OF THE WELLNESS PLAN

CASE NO: 03-1127-CR

CIRCUIT COURT OF INGHAM COUNTY, STATE OF MICHIGAN

DEADLINE TO DELIVER A PROOF OF CLAIM IS: 5:00 PM OCTOBER 24, 2003

See September 11, 2003 Court Order for additional instructions on filing your Claim.

CLAIMANT INFORMATION

Name Claimant: Catholic Charities of Shiawassee and Genesee Counties

Name and Address where notices should be sent: Deborah McCormack, President, 901 Chippewa St., Flint, MI 48503

Social Security Number: _____ Federal Tax ID Number 38-1359243

Provider ID Number: 1015211-0001

Name and Address of Claimant Attorney (if any): _____

CLAIM INFORMATION

Basis for Claim: ___ Goods Sold; X Services Performed; _____ Money Loaned;

_____ Personal Injury / Wrongful death; ___ Taxes; ____

Wages / Salary / Commissions / Compensation; ___ Settlement;

____ Medical Bills Paid by Member / Insured; ____ Other: _____

Claim description: (briefly state the date and facts of this claim or identify case name, court and docket number of prior litigation):
Counseling services provided beginning 3/25/02 through 8/28/03.

Total Amount of Claim on July 1, 2003: $72,614 The amount of all payments on this claim has been deducted for purposes of making this proof of claim: X Yes ____ No

Does claim include interest or other charges: ____Yes _X_ No If Claim includes interest or other charges **attach an itemized statement** of all interest and additional charges.

Is your Claim secured by collateral (including a right to setoff): ____ Yes _X_ No

Value of collateral: $_____

Brief Description of collateral:

_____

_____

By signing this Proof of Claim, Claimant certifies that the information and supporting documents are true and accurate. Claimant acknowledges that the Rehabilitator may request additional or supplemental information or evidence and may require testimony under oath, affidavits or written statements to support this Claim.

Signed this 6 th day of October, 2003.

Claimant's Signature: Deborah J McCormack

Type or print
Claimant Name: Deborah McCormack

Title: President

After completion, return this signed Proof of Claim to:

Claims by Medical Providers:

The Wellness Plan
P.O. Box 02577
Detroit, MI 48202
ATTN: Rehabilitation Claims

All other Creditor claims:

The Wellness Plan
2875 W. Grand Blvd.
Detroit, MI 48202
ATTN: Donn Merrill/AP Claims